Bureau of Insurance

A Report to the Joint Standing Committee on Insurance and Financial Services of the 121st Maine Legislature

Review and Evaluation of
LD 1353, an Act to Ensure Access to Women's Health Care Coverage for All Maine Women

Extraterritorial Mandates Review

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I. Executive Summary

The Joint Standing Committee on Insurance and Financial Services of the 121st Maine Legislature directed the Bureau of Insurance to review LD 1353, an Act to Ensure Access to Women's Health Care Coverage. In preparing the review and evaluation the Committee also requested review of existing mandated benefit laws that have been determined by the Bureau not to have extraterritorial application. The Committee further specified that our review need not use all the criteria outlined in 24-A M.R.S.A., §2752 but should focus on the financial impact on health insurance premiums if LD 1353 were enacted and amended to give all current mandated benefit laws extraterritorial application.

An extraterritorial mandate applies to certificates delivered in Maine even when the policy is issued in another state. For a mandate to be extraterritorial, the statute or the enacting law must specify that it applies to certificates as well as to policies or contracts issued in Maine.

LD 1353 would add an application provision for certificates to Maine law pertaining to current women's health mandated benefits. Several of these mandates are currently extraterritorial but the applicability section is in the unallocated law and not embedded in the statutory provision allocated to the Maine Revised Statutes. Including "certificate" in the statute would avoid confusion regarding the applicability of the mandate. Otherwise reference to "certificate" is only found in the unallocated language in the actual Public Law in the year it was enacted.

The following mandates are not currently extraterritorial:

a. Coverage of children born while coverage is in force from the moment of birth, including treatment of congenital defects;
b. Benefits for dentists' if the same services would be covered if performed by a physician;
c. Chiropractors to the extent that the same services would be covered by a physician. Benefits must be included for therapeutic, adjustive and manipulative services;
d. Equipment and supplies used to treat diabetes;
e. Screening Pap tests; and
f. Self-referred annual gynecological exam under managed care plans that otherwise require a primary care physician referral.

According to the National Association of Insurance Commissioners (NAIC), as of August 2002, 39 states had some type of diabetes mandate, 27 states had an annual Pap tests mandate and 3 states require coverage of congenital defects. See Appendix C for more

detail. The NAIC does not have a comparable chart for provider mandates. A report by Mercer Human Resource Consulting for the Maryland Health Care Commission in December 2002 stated that 45 states require insurance to cover chiropractic care.

Carriers with large group medical premiums in Maine were surveyed regarding the coverage they provide for Maine residents with out-of-state coverage. A summary of their responses can be found in Appendix D. The carriers reported about 56,100 lives with this type of coverage. Aetna provides the Maine HMO coverage regardless of where the situs of the group. Several carriers covered some but not all mandates or covered them to a lesser level than required in Maine. The majority of carriers did cover the non-extraterritorial Maine mandates.

Several factors determine the premium impact of extending the remaining mandated benefits extraterritorially. There would not be a large number of certificates impacted. This would only affect those certificates that do not already have the Maine level of mandated benefits included. Carriers responding to our questionnaire did not anticipate a significant cost to providing the Maine mandated level of benefits.

It is not possible to precisely measure the impact of mandated benefits. However, it is possible to estimate an outside limit, the maximum possible increase in health insurance premiums resulting from mandates. These estimates are based on the estimated portion of claim costs that mandated benefits represent, as detailed in Appendix E. The total estimated impact on premium for the mandates that are not currently extraterritorial is 1.97% for group HMO plans and 1.72% for group indemnity plans. The true cost impact is less than this because some of these services would likely be covered at some level in absence of a mandate and covering certain services or providers will reduce claims in other areas.

The United States General Accounting Office (GAO) in a September 2003 report on Private Health Insurance found that few studies have taken into account the fact that many businesses would offer some similar benefits even absent a mandate. Two studies they examined that did take this into account concluded that most of the benefits mandated would have been provided even in the absence of a mandate.

Carriers provided estimates of the cost impact of providing these additional mandates ranging from no impact to about 2.0% of total premium. No carrier reported an estimated cost increase to provide the newborn or dentist mandate.

We conclude that making all of the mandates extraterritorial would increase premiums

for certificates issued in Maine under out-of-state groups by no more than 2%.

II. Background

The Joint Standing Committee on Insurance and Financial Services of the 121st Maine Legislature directed the Bureau of Insurance to review LD 1353, an Act to Ensure Access to Women's Health Care Coverage. In preparing the review and evaluation the Committee also requested a review of existing mandated benefit laws that have been determined by the Bureau not to have extraterritorial application. The Committee further specified that our review need not cover all the criteria outlined in 24-A M.R.S.A., §2752 but should focus on the financial impact on health insurance premiums if LD 1353 were enacted and amended to give all current mandated benefit laws extraterritorial application.

An extraterritorial mandate applies to certificates delivered in Maine even when the policy is issued in another state. For example, employers that are located in another state but have an office or employees in Maine may cover those employees under a policy issued in the state where they are headquartered. For a mandate to be extraterritorial, the statute or the enacting law must specify that it applies to certificates as well as to policies or contracts issued in Maine.

LD 1353 would add an application provision for certificates to the following sections of Maine Law pertaining to current women's health mandated benefits:

- Maternity benefits and coverage of children provided to married women must also be provided to unmarried women;
- Newborn coverage including treatment of congenital defects;
- Reconstruction of both breasts to produce symmetrical appearance;
- Maternity length of stay and newborn care;
- Screening Pap tests;
- Breast cancer treatment;
- Contraceptives; and
- For managed care plans, annual gynecological exam without prior approval of primary care physician.

The bill modifies the applicability section of the mandate statute to include certificates. Several of these mandates are currently extraterritorial but the applicability section is in the unallocated law and not embedded in the statutory provision allocated to the Maine Revised Statutes. Including "certificate" in the statute would avoid confusion regarding the applicability of the mandate. Otherwise reference to "certificate" is only found in the unallocated language in the actual Public Law in the year it was enacted. These public

laws are not easy to access especially for years prior to 1996. There is often an application section in the statute that refers to policies and contracts but not to certificates leading the reader to assume that due to its omission it does not apply to certificates.

Extending mandates extraterritorially does not guarantee that all Maine residents have coverage for the mandated benefits. Self-funded plans would not have to comply with LD 1353.

III. Current Mandates

Appendix B lists the current mandates in Maine and notes whether they are extraterritorial. Because it is the policyholder who has the choice of adding a benefit, mandated offers do not apply to out-of-state policies. Federal law mandates coverage similar to Maine's mandates for "maternity length of stay" and mastectomy reconstruction. Therefore these are not considered further in this report. The following are the Maine mandates that are not currently extraterritorial:

- Children born while coverage is in force must be covered from the moment of birth, including treatment of congenital defects.
- Dentists' services must be covered to the extent that the same services would be covered if performed by a physician.
- Chiropractors' services must be covered to the extent that the same services would be covered if performed by a physician. Benefits must be included for therapeutic, adjustive and manipulative services. HMO plans must cover limited self referred treatment for acute care.
- Equipment and supplies used to treat diabetes must be covered.
- Screening Pap tests must be covered.
- Self-referred annual gynecological exam must be covered under managed care plans that otherwise require a primary care physician referral.

According to the National Association of Insurance Commissioners (NAIC) as of August 2002, 39 states had a diabetes mandate, 27 states had an annual pap smear mandate and 3 require congenital defects coverage. See Appendix C for more detail. The NAIC does not have a comparable chart for provider mandates. A report by Mercer Human Resource Consulting for the Maryland Health Care Commission in December 2002 stated that 45 states require insurance to cover chiropractic care.

IV. Carrier's Responses

Carriers with large group medical premiums in Maine were surveyed regarding the coverage they provide for Maine residents with out-of-state coverage. John Alden, National Health and New England Life reported no certificate holders in Maine with out-of-state large group policies. Anthem reported 46,281 certificate holders with an out-of-state policy and other carriers reported a combined total under 10,000. While this number may not represent all of those with this type of coverage it should be a fair representation of them.

Aetna Health did not provide the number of HMO certificates in Maine with an out-of-state policy but responded:

> Any insured HMO health plan has these benefits because the HMO 'policy' is written in Maine regardless of where the group is sitused. Therefore if the employer in California has a branch office in Maine and wants to offer those employees an HMO plan, those employees are enrolled in Aetna's Maine HMO and get all benefits as if the employer was in Maine. This does not pertain to any self-funded group and the self-funded group has authority to provide its own designed benefit plan.

According to Guardian Life, nine of the states where they write group policies have a newborn coverage mandate similar to Maine's and six states require coverage of the newborn if it is the first eligible dependent and is enrolled within 31 days of birth. Guardian Life also stated that in all states except for Maryland, Texas, Colorado and Washington, they currently cover Pap tests at the same level as Maine. In those four states, Pap tests are covered only if the plan elected the preventive care benefit. The cost impact to mandate coverage at the same level as Maine in these four states was estimated to be about 0.01%.

CIGNA covered all the services mentioned in the mandates but not to the same level of coverage as mandated in Maine. Trustmark coverage varied. Anthem did not provide information regarding coverage in time for this report. The majority of carriers reported covering the mandates. See Appendix D for further detail.

V. Financial Impact

Several factors determine the impact of extending the remaining mandated benefits extraterritorially. There would not be a large number of certificates impacted. This would only affect those certificates that do not already have the Maine level of mandated benefits included. It is hard to determine the extent to which the mandates are included in the benefits, even when not required by Maine law, due to mandates in other states and pressure from the insureds. Carriers responding to our questionnaire did not estimate a large cost to providing the Maine mandated level of benefits.

It is not possible to precisely measure the impact of mandated benefits. However, it is possible to estimate an outside limit, the maximum possible increase in health insurance premiums resulting from mandates. These estimates are based on the estimated portion of claim costs that mandated benefits represent, as detailed in Appendix E. The true cost impact is less than this for two reasons:

1. Some of these services would likely be provided and reimbursed even in the absence of a mandate, although we have tried to reflect some of this in the cost; and
2. It has been asserted (and some studies confirm) that covering certain services or providers will reduce claims in other areas. For instance, covering chiropractic services may reduce claims for back surgery. Covering screening mammograms may reduce claims for breast cancer treatment.

While both of these factors reduce the cost impact of the mandates, we are not able to estimate the extent of the reduction at this time. While some studies have estimated much higher costs for mandated benefits, these studies were not based on the specific mandates applicable in Maine and therefore are not relevant.

The United States General Accounting Office (GAO) in a September 2003 report on Private Health Insurance found that few studies have taken into account the fact that many businesses would offer some similar benefits even absent a mandate. Two studies they examined that did take this into account concluded that most of the benefits mandated would have been provided even in the absence of a mandate. The NAIC agreed with these findings stating that costs associated with benefit and provider mandates over what businesses normally incur are estimated to be relatively small.

The cumulative impact estimated in Appendix E for the mandates that are not currently extraterritorial is as follows:

- Newborn coverage: 0%
- Screening Pap Tests: 0 for HMO plans and 0.01% for group indemnity plans
- Annual GYN Exam Without Referral: 0.1% (HMO plans only)
- Diabetic Supplies: 0.2%
- Chiropractic: 1.56% for group HMO plans and 1.31% for group indemnity plans
- Dentists: 0.1% (indemnity plans only)
- **Total**: 1.86% for group HMO plans and 1.62% for group indemnity plans

Carriers provided estimates of the cost impact of providing these mandates ranging from no impact to about 2.0% of total premium. Great-West Life & Annuity and Alta Health & Life estimated 0.2% for Pap tests and 0.5% for gynecological exams for a total impact of 0.7%. They mentioned that the adjustment to administrative fees is very difficult to measure but estimated a 0.1-0.3% increase. Trustmark stated that the chiropractic benefit would add 0.3% to an annual premium. They also felt there would be a one time administrative cost in contract preparation, filing costs and claim system costs totaling $10,000. Guardian stated that they would not make changes to the rates but let the claim cost differential flow through the experience.

CIGNA stated that the Maine mandated benefit levels for chiropractic services for HMO plans is more comprehensive than the coverage provided by CIGNA plans in other states. Therefore the premiums would be increased by an estimated 1.43% and an administrative expense increase of 0.11% due to extending the chiropractic mandate. Likewise for the diabetic mandate, the premium increase was estimated at 0.48% and administrative expense 0.04%.

Harvard Pilgrim provides the Maine level of coverage to Maine residents enrolled through fully insured Massachusetts or New Hampshire employer policies though chiropractic services are not required in Massachusetts and it is a mandated offer in New Hampshire. They stated that requiring group coverage to vary based on the residence of the employee is onerous from an administrative perspective. As example, their claims system is configured to adjudicate claims based on the benefit package selected by the employer and they must manually process claims submitted by a Maine resident for services that would not otherwise be covered under the group plan.

Anthem did not provide information in time for the report about possible cost impact for those with out-of-state policies. No carrier reported an estimated cost increase to provide the newborn or dentist mandate.

Maryland conducts annual evaluations of their mandates, and estimates the total cost and

a marginal cost of each mandate. The marginal cost is the difference between the total cost and the cost of the services that would be covered in the absence of the mandate. In their December 2002 report they reported for diabetic equipment, supplies and education a full cost of 0.6% and a marginal cost of 0.2% as a percent of average cost per group policy.

Virginia issues a report on the impact of mandated benefits, offers and providers on premiums and claims experience from data submitted by insurance companies. Listed below is the percent of overall claims experience for group certificates for the mandates that are similar to those in Maine for 2000. The Virginia chiropractor mandate does not include the self-referred visits that are required in Maine.

- Newborn 0.97%
- Dentists 0.38%
- Chiropractor 0.47%
- Diabetes 0.33%
- Screening Pap tests 0.79%

We conclude that making all of the mandates extraterritorial would increase premiums for certificates issued in Maine under out-of-state groups by no more than 2%.

VI. Appendices

Appendix A: Letter Requesting Study with Proposed Legislation

Appendix B

HISTORY OF MANDATED HEALTH INSURANCE BENEFITS IN MAINE

Year Enacted	Benefit	Contracts Affected	Type of Mandate	Statutory Reference		PL#	ET*
				Title 24	Title 24-A		
1975	**Maternity** benefits provided to married women must also be provided to unmarried women.	All Contracts including HMOs	Mandated Coverage	§2318	§2741 §2832, §4234	**1975 Ch.276**	**Y**
1975	Coverage of children must be made available to **unmarried** women on the same basis as married women	All Contracts	Mandated Offer	§2318	§2742 §2833	**1975 Ch. 276**	**Y**
1975	Must include benefits for **dentists'** services to the extent that the same services would be covered if performed by a physician.	All Contracts	Mandated Provider	§2303-A	§2437	**1975 Ch.345**	**N**
1975	Family Coverage must cover any **children** born while coverage is in force from the moment of birth, including treatment of congenital defects.	All Contracts	Mandated Coverage	§2319	§2743 §2834	**1975 Ch.428**	**N**
1975	Must include benefits for **psychologists'** services to the extent that the same services would be covered if performed by a physician.	All Contracts	Mandated Provider	§2303	§2744 §2835	**1975 Ch.770**	**Y**
1977	Benefits must be made available for **home health care** services.	All Contracts	Mandated Offer	§2320	§2745, §2837	**1977 Ch.470**	**N**
1979	Benefits must be made available for outpatient health care services of certified **rural** health clinics.	Blue Cross Blue Shield	Mandated Offer	§2324			**N**
1981	Benefits must be made available for the services of **optometrists** if the same	All Groups	Mandated Offer	§2331	§2841	**1981 Ch.254**	**N**

	services would be covered if performed by a physician.						
1981	Benefits must be made available for treatment of **alcoholism** by licensed or certified treatment facilities subject "reasonable limitations".	All Groups	Mandated Provider	§2329	§2842		**Y**
1983	Benefits must include for treatment of alcoholism and drug dependency, subject to "reasonable limitations".	Groups of more than 20	Mandated Coverage	§2329	§2842		**Y**
1983 1995 2003	Benefits must be included for **Mental Health Services**, subject to "reasonable limitations". Requires coverage of listed diagnoses at levels not less extensive than for physical illnesses.	Groups of more than 20	Mandated Coverage	§2325-A	§2843 §4234-A		**Y**
1983	Benefits must be included for the services of **social workers** and psychiatric nurses to the extent that the same services would be covered if performed by a physician.	All Contracts	Mandated Provider	§2303	§2744 §2835	**1983 Ch.805 1987 Ch.80**	**Y**
1986	Benefits must be included for the services of **chiropractors** to the extent that the same services would be covered by a physician. Benefits must be included for therapeutic, adjustive and manipulative services.	All Contracts	Mandated Provider And Coverage	§2303-C	§2840-A §2748	**1985 Ch.516**	**N**
1987	Benefits must be made available for **cardiac rehabilitation** expenses.	Groups of 20 or more	Mandated Offer	§2333-A	§2845		**N**
1990	Benefits must be included for **AIDS,** AIDS Related Complex (ARC) or HIV related diseases to the extent that any other sickness or disabling condition is covered.	All Contracts	Mandated Coverage		§2750, §2846 §4229	**1989 Ch.176**	**Y**
1990	Benefits must be made	All	Mandated	§2320-A	§2837-A		**Y**

1997	available for screening **mammography**.	Contracts	Coverage		§2745-A,§4237-A		
1992	Benefits must be made available for the services of **acupuncturist** if comparable services would be covered if performed by a physician.	All Contracts	Mandated Offer	§2320-B	§2837-B §2745-B	**1995 Ch.671**	**N**
1994 1995 1997	Provide benefits for care by **chiropractors** at least equal to benefit paid to other providers treating similar neuro-musculoskeletal conditions. Requires treatment for acute care for a limited self referred for chiropractic benefits.	HMO Only	Mandated Provider And Coverage		§4236	**1993 Ch.669 1995 Ch.350 1997 Ch.99**	**N**
1995	Must provide coverage for **reconstruction of both breasts** to produce symmetrical appearance according to patient and physician wishes.	All Contracts	Mandated Coverage	§2320-C	§2745-C §2837-C, §4237	**1997 Ch.408**	**Y****
1995	Must provide coverage for **metabolic formula** and up to $3,000 per year for prescribed modified low-protein food products.	All Contracts	Mandated Coverage	§2320-C	§2745-C §2837-D, §4238		**Y**
1995	Must make available coverage for **listed mental illnesses** at levels not less expensive than for physical illnesses.	Individual Small Groups	Mandated Offer	§2325-A	§2843 §4234-A §2749-C		**Y**
1996	Benefits must be provided for maternity (**length of stay**) and newborn care, in accordance with "Guidelines for Perinatal Care" as determined by attending provider and mother.	All Contracts including HMOs	Mandated Coverage	§2318-A	§2743-A §2834-A,§4234-B	**1995 Ch.615**	**N****
1996	Benefits must be provided for medically necessary equipment and supplies used to treat **diabetes** (insulin, oral hypoglycemic agents, monitors, test strips, syringes and lancets)	All Contracts	Mandated Coverage	§2332-F	§2754 §2847-E §4240	**1995 Ch.592**	**N**

	and approved self-management and education training.						
1996	Benefits must be provided for **screening Pap tests**.	Group, HMOs	Mandated Coverage	§2320-E	§2837-E §4242	**1995 Ch.617**	**N**
1996	Benefits must be provided for **annual gynecological exam** without prior approval of primary care physician.	Group managed care including HMO	Mandated Coverage	§2322-F	§2847-F §4241	**1995 Ch.617**	**N**
1996	Benefits must be made available for mental health services provided by **licensed counselors**.	All Contracts including HMOs	Mandated Offer	§2303	§2744(3),§2835(3) §4234-A(8-A)	**1995 Ch.561 1997 Ch.174**	**N**
1997	Benefits provided for **breast cancer treatment** for a medically appropriate period of time determined by the physician in consultation with the patient.	All Contracts	Mandated Coverage	§2320-C	§2745-C §2837-C, §4237	**1997 Ch.408**	**Y**
1998	Coverage required for **off-label use of prescription drugs** for treatment of cancer, HIV, or AIDS.	All Contracts	Mandated Coverage	§2320	§2745-E, §2745-F, §2837-F, §2837-G, §4234-D, §4234-E	**1997 Ch.701**	**Y**
1998	Coverage required for **prostrate cancer screening**: Digital rectal examinations and prostate-specific antigen tests covered if recommended by a physician, at least once a year for men 50 years of age or older until age 72.	All Contracts	Mandated Coverage	§2325-C	§2745-G, §2837-H, §4244	**1997 Ch.754**	**Y**
1999	Coverage of **nurse practitioners and nurse midwives** and allows nurse practitioners to serve as primary care providers.	All Managed Care Contracts	Mandated Provider	§2332-K	§2757, §2847-H, §4248	**1999 Ch.396**	**Y**
1999	Prescription drug coverage must include **contraceptives**.	All Contracts	Mandated Coverage	§2332-J	§2756, §2847-G, §4247	**1999 Ch.341**	**Y**
1999	Coverage of **registered**	All	Mandated	§2332-L	§2758, §2847-I,	**1999**	**Y**

	nurse first assistants.	Contracts	Provider and Coverage		§4246	**Ch.412**	
2000	Access to clinical trials.	All Contracts	Mandated Coverage		§4310	**1999 Ch.742**	**Y**
2000	Access to **prescription drugs** for contracts that provide coverage for prescription drugs and medical devices.	All Managed Care Contracts	Mandated Coverage		§4311	**1999 Ch.742**	**Y**
2001	Coverage of **hospice care** services	All Contracts	Mandated Coverage		§2759, §2847-J, §4250	**2001 Ch.358 Part LL**	**Y**
2001	Coverage of general **anesthesia for dentistry.**	All Contracts	Mandated Coverage	§2332-M	§2760, §2847-K, §4251	**2001 Ch.423**	**Y**
2001	Access to **eye care providers.**	All Managed Care Contracts	Mandated Coverage		§4314	**2001 Ch.408**	**Y**
2003	Coverage of **prosthetic devices** to replace in whole or part an arm or leg. Effective 1/04	All Contracts	Mandated Coverage		§4315	**2003 Ch.459**	**Y**
2003	Coverage of **licensed clinical professional counselors**. Effective 1/04	All Contracts	Mandated Coverage		§2744, §2835, §4234-A	**2003 Ch.65**	**Y**

*ET (Extraterritorial) This column states whether the mandate applies to certificates issued in Maine through group policies that are issued outside of Maine.
** Similar mandate in Federal Law

Appendix C: Other States' Mandated Health Insurance Benefits

CANCER TESTS: PAP SMEARS

10/02

STATE	CITATION	SUMMARY
AK	§§ 21.42.375, 21.42.395	Cover annual pap smears for persons 18 or older, subject to usual circumstance and deductibles.
CA	Ins. § 10123.18; Health & Safety § 1367.66 Ins. § 10123.83, H&S § 1367.64	Pap smear annually. Beginning 1/1/02, includes option of any cervical cancer screening test approved by the FDA. Every individual and group health care service plan or health insurance policy must cover all medically accepted cancer screening tests.
DE	Tit. 18 §§ 3344; 3552; 3559	Annual pap smear. Benefit should not exceed least expensive charge in area
DC	§§ 31-2902 to 31-2903; 31-2932	Pap smear annually. Not subject to co-insurance and deductibles.
GA	§§ 33-29-3.2; 33-30-4.2 § 33-24-56.3	Annual pap smear. Deductibles and exclusions subject to commissioner approval. Surveillance tests for women age 35 and older at risk for ovarian cancer.
IL	215 ILCS 5/356g; 215 ILCS 125/4-6.1	Pap tests annually.
KS	§§ 40-2164; 40-2230	Coverage for mammograms and pap smears performed at direction of doctor. Prostate cancer screening for men 40 and older in high risk category, for all men age 50 and older.
LA	§ 215.11	Annual Pap test.
ME	24 § 2320-A; 24-A § 2745-A; 24-A § 2837-A	Must provide coverage for pap tests recommended by a physician.
MA	ch. 175:47G; 176A:8J; 176G:4	Annual pap screening.
MN	§§ 62A.30; 62Q.50	Routine screening procedures, such as pap smears, when ordered by physician.
MS	§ 83-9-108	Insurers must offer coverage for annual mammograms for all women 35 years of age and older.
MO	§ 376.1406	Pelvic exam and pap smear for nonsymptomatic women in accordance with American Cancer Society guidelines. Subject to same coinsurance and deductibles as other benefits.
NV	§§ 689B.0374; 695C.1735; 689A.0405; 695B.1912	Annual Pap smear for women age 18 and older.

CANCER TESTS: PAP SMEARS

11/02

STATE	CITATION	SUMMARY
NJ	§§ 17B:27-46-1f, 17B:27-46.1n; 17:48-6g, 17:18-6o; 17:48E-35.4, 17:48E-35.12; 17B:26-2.1e; 17:48A-7f, 17:48A-7m; 17:48E-35.13; 17:48-6p; 17:48A-7n; 17B:27-46.10	Group plans must cover Pap smear to same extent as for any other medical condition
NM	§§ 59A-22-39 to 59A-22-40; 59A-46-41	Pap test yearly for women age 18 and older.
NY	Ins. Law §§ 3216(i); 3221(l); 4303(p)	Annual pap smear.
NC	§§ 58-3-179; 58-51-57; 58-67-76; 58-65-92; 58-51-58	Pap smears covered with same deductibles and coinsurance as other procedures.
OH	§§ 3923.52; 1742.40 and 1751.62	pap smear.
OR	§§ 743.727 to 743.728	Every health insurance policy shall provide coverage for breast cancer screening and pap smears.
PA	§§ 40-39-124; 40-39-904	Annual gynecological exam, including pelvic exam and clinical breast exam; routine pap smear.
RI	§§ 42-62-26; 27-20-17, 27-19-19 to 27-19-22; 27-41-30 to 27-49-32; 27-18-40 to 27-18-43	Coverage for mammograms and pap smears in accordance with American Cancer Society Guidelines. Payment only need be made if the facility meets quality assurance standards.
SC	§ 38-71-145	Cover pap smear yearly, or more often at doctor's recommendation.
VT	tit. 8 § 4100a	Annual screening for females 50 years or older, for those younger upon recommendation of provider; subject to same coinsurance and deductible as other radiological exams.
VA	§§ 38.2-3418.1 to 38.2-3418.3; 38.2-3418.7; 38.2-3418.7:1	Insurers shall provide coverage for annual pap smears.
WV	§§ 33-15-15; 33-16C-4, 33-15-4C, 33-16-3g; 33-25-8a; 33-25A-8a	Pap smear annually for women. Coinsurance and deductible apply to mammograms and pap smears.
WY	§ 26-19-107	Group policy to include pap smear, all without a deductible due. Health plan must cover up to 80% of cost, with maximum of $250 per year.

DIABETES

11/02

STATE	CITATION	SUMMARY
AK	§ 21.42.390	A contract covering pharmacy services must include coverage for diabetes treatment, including medication, equipment and supplies.
AZ	§§ 20-826, 20-934, 20-1057, 20-1342, 20-1402, 20-1404, 20-2325	Any contract covering diabetes must include coverage for equipment and supplies that are medically necessary, including blood glucose monitors, test strips, syringes, etc.
AR	§§ 23-79-602, 23-79-603	Every policy or subscriber contract must include one per lifetime training program per insured for diabetes self-management training where medically necessary. Must include coverage for equipment, supplies and services for treatment of diabetes.
CA	Ins. § 10176.61; Health & Safety § 1367.51	Every policy shall offer diabetic self-management education programs. Insurance and health care service plans shall include equipment and supplies, including blood glucose monitors and test strips, insulin pumps, lancets, syringes, insulin, etc.
CO	§ 10-16-104(13)	Provide coverage for equipment, supplies, and outpatient self-management training and education, including medical nutrition therapy.
CT	§ 38a-492(d)	Provides medically necessary equipment, laboratory and diagnostic tests for individual policies.
DC	Act 13-386 (2000)	Provide coverage for equipment, supplies, self-management training and education for treatment of diabetes. May not require higher deductible or copayment.
FL	§ 627.6408	Covers medically appropriate and necessary equipment, supplies and training in the treatment of diabetes.
GA	§ 33-24-59.2	All policies and plans must offer coverage for medically necessary equipment, supplies, pharmacological agents, and out-patient self-therapy as prescribed by a physician.
IL	215 ILCS 5/356w	Group policy shall provide coverage for training and education on diabetes self-management, equipment, supplies.

DIABETES (Cont.)

8/02

STATE	CITATION	SUMMARY
IN	§§ 27-8-14.5-4, 27-8-14.5-6	Provide medically necessary supplies and equipment.
KY	§ 304.17A-148; Reg. 806 KAR 17:150	All health benefit plans must cover equipment, supplies and necessary training for the treatment of insulin dependent diabetes, subject to the same deductibles and coinsurance.
LA	§ 22:215.21	Provide coverage for equipment, supplies and outpatient self-management training for diabetes. Does not apply to individually underwritten policy.
ME	tit. 24 §§ 2332-F; 2754; 2847-E; 4240	Covers medically appropriate and necessary equipment as certified by the treating physician, insulin, oral hypoglycemic agents, monitors, test strips, syringes and lancets and out-patient self-management training and educational services. Educational services shall be authorized by the State's Diabetes Control Project.
MA	§§ 175:47N; 176A:8P; 176B:4P; 176G:4H	Provide coverage for blood-glucose monitoring strips for treatment of insulin-dependent diabetes.
MI	§ 500.3406p	Program to prevent onset of diabetes, including diet, lifestyle, fitness, etc. Cover supplies needed for diabetes treatment at same deductible and coinsurance provisions as medical equipment or prescriptions. Cover outpatient self-management training and education, and medications used in foot ailments, infections and other associated conditions.
MN	§ 62A.45	Cover supplies needed for diabetes treatment at same deductible and coinsurance provisions as medical equipment or prescriptions. Cover outpatient self-management training and education, including medical nutrition therapy.
MS	§ 83-9-46	Offer coverage for equipment and supplies used in connection with diabetes management, including supplies for monitoring blood glucose and insulin self-administration.
MT	§ 33-22-129	Group coverage must include coverage for out-patient self-management training for treatment of diabetes. Must cover at least $250 benefit per person. Also must provide coverage for equipment and supplies: insulin, syringes, injection aids, devises for monitoring glucose levels, insulin pump and oral prescriptions. Annual copayment and deductibles same as other covered benefits.

DIABETES (Cont.)

8/02

STATE	CITATION	SUMMARY
NE	§ 44-790	All health benefit plans must cover equipment, supplies and necessary training for the treatment of insulin dependent diabetes, subject to the same deductibles and coinsurance.
NV	§§ 689A.0427; 689B.0357; 695B.1927; 695C.1727	Cover training and education for self-management of diabetes, subject to same coinsurance and deductibles as for other covered conditions.
NH	§§ 415:6-e; 415:18-f; 420-A:17-a; 420-B:8-k	Provide to residents coverage for medically appropriate and necessary outpatient self-management training, including medical nutrition therapy.
NJ	17:48-6n ; 17:48A-7l; 17:48E-35.11; §§ 17B:26-2.1*l*; 17B:27-46.1m	Provide coverage for equipment and supplies needed for treatment of diabetes.
NM	§§ 59A-22-41; 59A-96-43	Covers medically appropriate and necessary equipment as certified by the treating physician, insulin, oral hypoglycemic agents, monitors, test strips, syringes, injection aids, and lancets and out-patient self-management training and educational services, subject to coinsurance and deductibles consistent with other benefits.
NC	§§ 58-51-61; 58-65-91; 58-67-74	Must provide coverage for diabetes self-management training, supplies and equipment and laboratory procedures.
OK	tit. 36 § 6060.1	Provide coverage for equipment and supplies to treat Type I or Type II and gestational diabetes
OR	§ 743.694	Group health plans shall include coverage for supplies and equipment to treat diabetes, and diabetes self-management training programs.
PA	§ 40-39-126	Provide coverage for equipment, supplies and self-management education for control of diabetes. Subject to same deductibles, copayments or coinsurance requirements imposed for similar coverages.
RI	§§ 27-18-38; 27-19-35; 27-20-22; 27-41-44	Provide coverage for equipment and supplies to treat insulin treated diabetes, non-insulin treated diabetes and gestational diabetes. Includes medically necessary visits to medical nutrition therapy.
SC	§ 38-71-46	Provide coverage for medical treatment, equipment, supplies and self-management training for treatment of diabetes.
SD	§ 58-17-1.2	Covers equipment and supplies for non-insulin dependent and insulin dependent persons. Includes blood glucose monitors and other supplies. Education for self-management of diabetes shall also covered.

STATE	CITATION	SUMMARY
TN	§ 56-7-2605	Covers medically appropriate and necessary equipment as certified by the treating physician, insulin, oral hypoglycemic agents, monitors, test strips, syringes, injection aids, and lancets and out-patient self-management training and educational services, subject to coinsurance and deductibles consistent with other benefits.
TX	I.C. art. 21.53G	Health benefit plan that covers diabetes must also cover diabetes equipment supplies and self-management training programs. May be subject to deductible and coinsurance no greater than that for other conditions.
UT	§ 31A-22-625; Reg. R590-200	Coverage for diabetes subject to same deductibles and coinsurance as other services. Covers diabetes self-management training, supplies and insulin.
VT	tit. 8 § 4089c	Insurer shall provide coverage for equipment, supplies and self-management training for diabetes.
VA	§ 38.2-3418.8	Cover equipment and supplies and out-patient self-management training.
WA	§§ 48.20; 48.21; 48.44; 48.46	Plans or contracts that include pharmacy services shall provide appropriate and medically necessary equipment and supplies, as prescribed. All plans or contracts shall provide out-patient self-management training and education, including medical nutrition therapy.
WV	§ 33-16-16	Major medical plans shall cover equipment and supplies for non-insulin dependent and insulin dependent persons. Includes blood glucose monitors and other supplies. Education for self-management of diabetes shall also covered.
WY	§ 26-20-201	Covers equipment and supplies for non-insulin dependent and insulin dependent persons. Includes blood glucose monitors and other supplies.

Appendix D: Carriers' Responses

CARRIER'S COVERAGE OF MANDATES AND ESTIMATED IMPACT

Insurance Carrier	# ME certificates for out-of-state policy	Premium for ME	Dentists	Newborn	Chiropractic	Diabetes	Pap Tests	Self-referred GYN	General Costs
Aetna Health (non-HMO)	1,700	$2,600,000	Covered	Covered	Covered	Covered	Covered	N/A	None
Allianz	624	$5,007,219 total in ME	Covered	Covered	Covered	Covered	Covered	N/A	None
Alta Health & Life	2	2,290	Covered	Covered	Covered	Covered	Depends on state	Covered	Negligible 0.7-1.0%
Anthem BC	46,281		Varies by contract and state of situs						
CIGNA	<100	Not available	Covered	Covered	Some coverage. ME level would increase costs	Limited ME level increase costs w/ no max	Covered w/preventive benefits	Covered w/preventive benefits	Depends on type of coverage Max: 2.18%
Great West and Annuity	10	8,998	Covered	Covered	Covered	Covered	Depends on state	Covered	Negligible 0.7-1.0%
Guardian Life	206	954,660	No info	Covered	Covered	Covered	Depends on state	N/A	Admin costs difficult to determine
Harvard Pilgrim	6,203	Not available	Covered	Covered	Covered	Covered	Covered	Covered	Admin costs
Metropolitan Life	80 situsedin FL & IL	$14,754	Covered	Covered	Covered	Covered	IL covered FL maybe	Covered	Negligible 0.7-1.0%
New York Life	140	No info	Covered	Covered	Covered	Covered	Covered	Covered	None
Trustmark	259	$583,870 total lg group in ME		Covered on family plans	Not covered	Specific to policy	100% coverage	N/A	$10K filing and claims administration costs
UNICARE	494	$827,173 total in ME	Covered	Covered	Covered	Covered	Covered	N/A	None
United Healthcare	No information to provide								

Appendix E: Cumulative Impact of Mandates

Following are the estimated costs for the existing mandates. The estimates for mental health, substance abuse, chiropractic, and screening mammography reflect the total cost of the benefits mandated. Estimates for other mandates reflect the impact of the mandate net of benefits that would have been covered even without the mandate.

- ***Mental Health*** (Enacted 1983) – The mandate applies only to groups of more than 20. Mental health parity for listed conditions was effective 7/1/96. The list of conditions for which parity is required was expanded effective 10/1/03. The amount of claims paid has been tracked since 1984 and has historically been in the range of 3% to 4% of total group health claims. The percentage had been decreasing in recent years from a high of 4.16% in 1997 to 3.27% in 2000, but held steady at 3.33% in 2001 and 2002. For 2001, this broke down as 3.22% for HMOs and 3.67% for indemnity plans. For 2002, this disparity increased to 2.72% for HMOs and 5.11% for indemnity plans. We assume an average of the 2001 and 2002 levels going forward, but add ¾ of a percentage point to reflect the expansion of the list of conditions for which parity is required. Although it is likely that some of these costs would be covered even in the absence of a mandate, we have no basis for estimating how much. We have included the entire amount, thereby overstating the impact of the mandate to some extent.

- ***Substance Abuse*** (Enacted 1983) – The mandate applies only to groups of more than 20 and originally did not apply to HMOs. Effective 10/1/03, substance abuse was added to the list of mental health conditions for which parity is required. This applies to HMOs as well as indemnity carriers. The amount of claims paid has been tracked since 1984. Until 1991, it was in the range of 1% to 2% of total group health claims. This percentage showed a downward trend from 1989 to 2000 when it reached 0.31% and increased to 0.37% in 2001 and to 0.66% in 2002. The long-term decrease was probably due to utilization review, which has sharply reduced the incidence of inpatient care. Inpatient claims decreased from about 93% of the total in 1985 to about 55% in 2001 but increased to 62% in 2002. The 0.66% for 2002 broke down as 0.62% for HMOs and 0.77% for indemnity plans. We estimate substance abuse benefits to remain at the current level, but add ¼ of a percentage point to reflect the expansion of the list of conditions for which parity is required. Although it is likely that some of these costs would be covered even in the absence of a mandate, we have no basis for estimating how much. We have included the entire amount, thereby overstating the impact of the mandate to some extent.

- ***Chiropractic*** (Enacted 1986) – The amount of claims paid has been tracked since 1986 and has been approximately 1% of total health claims each year. However, the percentage increased from 0.84% in 1994 to 1.51% in 2000. Since then, it decreased to 1.32% in 2001 and then increased to 1.45% in 2002. The level varies significantly between group and individual and between HMOs and indemnity plans. We estimate that going forward. The level will be continue at the 2002 level of 1.56% for

group HMO plans, 1.31% for group indemnity plans, 0.35% for individual HMO plans, and 0.46% for individual indemnity plans. Although it is likely that some of these costs would be covered even in the absence of a mandate, we have no basis for estimating how much. We have included the entire amount, thereby overstating the impact of the mandate to some extent.

- ***Screening Mammography*** (Enacted 1990) – The amount of claims paid has been tracked since 1992. It increased from 0.11% of total claims in 1992 to 0.59% in 2001, which may reflect increasing utilization of this service. 2002 figures are not comparable to earlier years because one major company erroneously included Medicare supplement business in previous reports. The 2002 figure of 0.7% is therefore more accurate. This figure broke down as 0.72% for group HMO plans, 0.65% for group indemnity plans, .43% for individual HMO plans, and 0.73% for individual indemnity plans. The individual HMO data is not credible and the other variations are insignificant. We estimate the 0.70% in all categories going forward. Although it is likely that some of these costs would be covered even in the absence of a mandate, we have no basis for estimating how much. We have included the entire amount, thereby overstating the impact of the mandate to some extent.

- ***Dentists*** (Enacted 1975) – This mandate requires coverage to the extent that the same services would be covered if performed by a physician. It does not apply to HMOs. A 1992 study done by Milliman and Robertson for the Mandated Benefits Advisory Commission estimated that these claims represent 0.5% of total health claims and that the actual impact on premiums is "slight." It is unlikely that this coverage would be excluded in the absence of a mandate. We include 0.1% as an estimate.

- ***Breast Reconstruction*** (Enacted 1998) – At the time this mandate was being considered in 1995, Blue Cross and Blue Shield of Maine estimated the cost at $0.20 per month per individual. We have no more recent estimate. We include 0.02% in our estimate of the maximum cumulative impact of mandates.

- ***Errors of Metabolism*** (Enacted 1995) – At the time this mandate was being considered in 1995, Blue Cross estimated the cost at $0.10 per month per individual. We have no more recent estimate. We include 0.01% in our estimate.

- ***Diabetic Supplies*** (Enacted 1996) – Our report on this mandate indicated that most of the 15 carriers surveyed in 1996 said there would be no cost or an insignificant cost because they already provide coverage. One carrier said it would cost $.08 per month for an individual. Another said .5% of premium ($.50 per member per month) and a third said 2%. We include 0.2% in our estimate.

- ***Minimum Maternity Stay*** (Enacted 1996) – Our report stated that Blue Cross did not believe there would be any cost for them. No other carriers stated that they required shorter stays than required by the bill. We therefore estimate no impact.

- ***Pap Smear Tests*** (Enacted 1996) – No cost estimate is available. HMOs would typically cover these anyway. For indemnity plans, the relatively small cost of this test would not in itself satisfy the deductible, so there would be no cost unless other services were also received. We estimate a negligible impact of 0.01%.

- ***Annual GYN Exam Without Referral*** (managed care plans) (Enacted 1996) – This only affects HMO plans and similar plans. No cost estimate is available. To the extent the PCP would, in absence of this law, have performed the exam personally rather than referring to an OB/GYN, the cost may be somewhat higher. We include 0.1%.

- ***Breast Cancer Length of Stay*** (Enacted 1997) – Our report estimated a cost of 0.07% of premium.

- ***Off-label Use Prescription Drugs*** (Enacted 1998) – The HMOs claimed to already cover off-label drugs, in which case there would be no additional cost. However, providers testified that claims have been denied on this basis. Our 1998 report did not resolve this conflict but stated a "high-end cost estimate" of about $1 per member per month (0.6% of premium) if it is assumed there is currently no coverage for off-label drugs. We include half this amount, or 0.3%.

- ***Prostate Cancer*** (Enacted 1998) – No increase in premiums should be expected for the HMOs that provide the screening benefits currently as part of their routine physical exam benefits. Our report estimated additional claims cost for indemnity plans would approximate $0.10 per member per month. With the inclusion of administrative expenses, we would expect a total cost of approximately $0.11 per member per month, or about 0.07% of total premiums.

- ***Nurse Practitioners and Certified Nurse Midwives*** (Enacted 1999) – This law mandates coverage for nurse practitioners and certified nurse midwives and allows nurse practitioners to serve as primary care providers. This mandate is estimated to increase premium by 0.16%.

- ***Coverage of Contraceptives*** (Enacted 1999) – Health plans that cover prescription drugs are required to cover contraceptives. This mandate is estimated to increase premium by 0.8%.

- ***Registered Nurse First Assistants*** (Enacted 1999) – Health plans that cover surgical first assisting are mandated to cover registered nurse first assistants if an assisting physician would be covered. No material increase in premium is expected.

- ***Access to Clinical Trials*** (Enacted 2000) – Our report estimated a cost of 0.46% of premium.

- ***Access to Prescription Drugs*** (Enacted 2000) – This mandate only affects plans with closed formularies. Our report concluded that enrollment in such plans is minimal in Maine and therefore the mandate will have no material impact on premiums.

- ***Hospice Care*** (Enacted 2001) – No cost estimate was made for this mandate because the Legislature waived the requirement for a study. Since carriers generally cover hospice care already, we assume no additional cost.

- ***Access to Eye Care*** (Enacted 2001) – This mandate affects plans that use participating eye care professionals. Our report estimated a cost of 0.04% of premium.

- ***Dental Anesthesia*** (Enacted 2001) – This mandate requires coverage for general anesthesia and associated facility charges for dental procedures in a hospital for certain enrollees for whom general anesthesia is medically necessary. Our report estimated a cost of 0.05% of premium.

- ***Prosthetics*** (Enacted 2003) – This mandate requires coverage for prosthetic devices to replace an arm or leg. Our report estimated a cost of 0.03% of premium for groups over 20 and 0.08% for smaller groups and individuals.

- ***LCPCs*** (Enacted 2003) – This mandate requires coverage of licensed clinical professional counselors. Our report on mental health parity indicated to measurable cost impact for coverage of LCPCs.

These costs are summarized in the following table.

COST OF EXISTING MANDATED HEALTH INSURANCE BENEFITS

Year Enacted	Benefit	Type of Contract Affected	Est. Maximum Cost as % of Premium	
			Indemnity	HMO
1975	**Maternity** benefits provided to married women must also be provided to unmarried women.	All Contracts	0[1]	0[1]
1975	Must include benefits for **dentists'** services to the extent that the same services would be covered if performed by a physician.	All Contracts except HMOs	0.1%	--
1975	Family Coverage must cover any **children** born while coverage is in force from the moment of birth, including treatment of congenital defects.	All Contracts except HMOs	0[1]	--
1983	Benefits must be included for treatment of **alcoholism and drug dependency**.	Groups of more than 20	1.02%	0.87%
1975 1983 1995	Benefits must be included for **Mental Health Services**, including psychologists and social workers.	Groups of more than 20	5.14%	3.72%
1986 1994 1995 1997	Benefits must be included for the services of **chiropractors** to the extent that the same services would be covered by a physician. Benefits must be included for therapeutic, adjustive and manipulative services. HMOs must allow limited self referred for chiropractic benefits.	Group	1.31%	1.56%
		Individual	0.46%	0.35%
1990 1997	Benefits must be made available for screening **mammography**.	All Contracts	0.7%	0.7%
1995	Must provide coverage for **reconstruction of both breasts** to produce symmetrical appearance according to patient and physician wishes.	All Contracts	0.02%	0.02%
1995	Must provide coverage for **metabolic formula** and up to $3,000 per year for prescribed modified low-protein food products.	All Contracts	0.01%	0.01%
1996	Benefits must be provided for **maternity (length of stay)** and newborn care, in accordance with "Guidelines for Perinatal Care."	All Contracts	0	0
1996	Benefits must be provided for medically necessary equipment and supplies used to treat **diabetes** and approved self-management and education training.	All Contracts	0.2%	0.2%
1996	Benefits must be provided for **screening Pap tests**.	Group, HMOs	.01%	0
1996	Benefits must be provided for **annual gynecological exam** without prior approval of primary care physician.	Group managed care	--	0.1%
1997	Benefits provided for **breast cancer treatment** for a medically appropriate period of time determined by the physician in consultation with the patient.	All Contracts	.07%	.07%
1998	Coverage required for **off-label use of prescription drugs** for treatment of cancer, HIV, or AIDS.	All Contracts	0.3%	0.3%
1998	Coverage required for **prostrate cancer screening**.	All Contracts	.07%	0
1999	Coverage of nurse **practitioners and nurse midwives** and allows nurse practitioners to serves as primary care providers.	All Managed Care Contracts		0.16%
1999	Prescription drug must include **contraceptives.**	All Contracts	0.8%	0.8%
1999	Coverage for **registered nurse first assistants.**	All Contracts	0	0
2000	Access to **clinical trials.**	All Contracts	0.46%	0.46%

[1] This has become a standard benefit that would be included regardless of the mandate.

2000	Access to **prescription drugs.**	All Managed Care Contracts	0	0
2001	Coverage of **hospice care services** for terminally ill.	All Contracts	0	0
2001	Access to **eye care**	Plans with participating eye care professionals	0	0.04%
2001	Coverage of **anesthesia** and facility charges for certain **dental** procedures	All Contracts	0.05%	0.05%
2003	Coverage for **prosthetic devices** to replace an arm or leg	Groups >20	.03%	.03%
		All other	.08%	.08%
2003	Coverage of licensed clinical professional counselors	All Contracts	0	0
Total cost for groups larger than 20:			**10.29%**	**9.09%**
Total cost for groups of 20 or fewer:			**4.18%**	**4.55%**
Total cost for individual contracts:			**3.32%**	**3.24%**